Fina King County

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Public Health
Seattle & King County

April 13, 2012

Bea Rector, Aging & Disability Services Administration
Barbara Lanz, Health Care Authority
State of Washington
PO Box 45600
Olympia, WA 98504-5600

Dear Ms. Rector and Ms. Lantz:

On behalf of Public Health-Seattle & King County and the King County Department of Community and Human Services, thank you for the opportunity to comment on the February 22, 2012 draft Health Home Proposal issued by the Health Care Authority and the Department of Social and Health Services.

We are pleased that Washington State is taking steps to develop a program of health homes for Medicaid enrollees with chronic conditions as provided for under Section 2703 of the Affordable Care Act. Over 200,000 residents of King County rely on the Medicaid program for their health services, and significant numbers of them face one or more chronic health conditions such as asthma, diabetes, hypertension, obesity, HIV, mental illness, and substance use disorders, among others.

Our comments are organized into three sections: (1) key elements of the health home model that King County supports; (2) four areas of most significant concern and associated recommendations; and (3) other recommendations.

1. Key elements of the model that King County supports:

- **Local level focus**. We appreciate your recognition of inter-relatedness of medical, behavioral, long-term care, and social service needs for the Medicaid population, and the intent to design a health home model that is therefore organized and delivered at the local level. This fundamental principle is consistent with the vision that King County stakeholders have articulated for the future design of the health safety net system.
- **Evidence of moving toward a "whole person" approach**. As outlined in the State Medicaid Director letter, health homes are expected to embrace a "whole person" approach, providing services and linkages that address both clinical and non-clinical needs. A number of features of the proposed model – specifically, the acknowledgement of regional consortiums as eligible health homes, the expectation that health homes develop interdisciplinary "networks," the recognition that health home services may be delivered in community-based settings, and the references to the use of peer support and community health workers – all reinforce a client-centered, whole person approach.

2. Four areas of most significant concern and recommendations

- **Recognize and foster local public health roles in health home networks.** We are pleased that the standards include an expectation of wellness and health promotion activities, such as smoking prevention and cessation, nutrition counseling, disease-specific programs, and others. Public Health-Seattle & King County and other local health jurisdictions play substantial roles in providing or arranging for these chronic disease prevention and management services. We also reach certain high-risk Medicaid clients through tuberculosis (TB), sexually transmitted disease (STD), human immunodeficiency virus (HIV), Jail Health, Children with Special Health Care Needs, and homeless programs. Under the description of health home networks in the "general requirements" section of the proposal, we strongly recommend that local public jurisdictions be called out as likely members of health home networks.
- **Create incentives for efficient, well-coordinated health home networks in given localities**. As managed care organizations (MCOs) and various health programs working with Medicaid clients begin to explore health home network leadership or participation, the potential exists for significant inefficiencies, especially if multiple providers or MCOs simultaneously attempt to create an infrastructure with the same set of community-based human services, public health, and housing programs, for example. The State should create incentives for localities to design efficient "packaging" of local services that are needed by the major subsets of the chronically ill, creating the infrastructure just once in a given region. This will help ensure that health home networks are highly efficient and not tripping over each other in ways that worsen rather than resolve fragmentation.
- **Do not limit eligibility to those with PRISM scores of >1.5.** While we recognize the budgetary importance of addressing the high cost, high risk population and demonstrating return on investment within the two-year period, the requirement that health home services may be provided only to those with risk scores of 1.5 or greater is overly restrictive and may hamper implementation. Medical and behavioral health providers may be forced to watch patients with complex conditions decline further before they can activate the needed interdisciplinary services of the health home team, at a time when an earlier intervention would clearly reduce long-term costs and prevent further decline and suffering. With the ability to access 90 percent federal match, the State should use this rare opportunity to design a health home model that can serve a broader group of Medicaid clients with chronic health conditions, using a tiered payment approach to serve those who have not reached the 1.5 PRISM score.
- **Eligibility – clarify specific conditions, add substance use disorders, mental health disorders, and HIV.** It remains unclear what chronic health conditions and combinations trigger eligibility for health home services. The list provided in the Eligibility section says that beneficiaries must have complex medical needs that "may include one or more" of the conditions on the list, language that differs from the federal criteria. Given the characteristics of the target population, we are especially concerned by the omission of substance abuse disorders, which is one of the six specific eligible conditions listed in the federal guidelines for Health Homes. We strongly recommend its addition. Also of concern is the limitation of mental health conditions to only "depression" or "severe mental illness" rather than the broader category of "mental health conditions" in the federal population criteria. Finally, we question the omission of HIV from the list and recommend that it be added in order to establish a health home model that addresses the needs of that population group.

3. Other recommendations

- **Reducing health disparities should be added as a guiding principle**. We recommend that you add as a guiding principle that health homes must support the reduction of health disparities due to chronic illness by reaching social and ethnic groups that are disproportionately affected. To facilitate planning of responsive health home networks, the state should provide county-level data on the specific geographic areas, demographics, health conditions, and health providers working with the Medicaid population targeted for health home services.
- **Support planning and implementation infrastructure.** The proposal does not address the infrastructure that will be needed to establish health home networks. While a given managed care organization, primary care program, behavioral health agency, or other community agency may be able to meet some of the standards, it seems unlikely that few would have *all* components and partnerships in place, especially given the aggressive timeline. Intensive development of partnerships, protocols, working agreements, and workflows will need to occur. Technology infrastructure may be lacking among some parties within a health home network. Physical space, cars, mobile technologies, training, and safety protocols/equipment represent needs and costs facing interdisciplinary teams working with high risk populations. The State should consider ways that the 2703 SPA could request funding to support initial infrastructure costs, especially in the first two quarters.
- **Include jail health in care transitions and health home networks.** A subset of high-risk, high cost Medicaid clients have frequent contact with the justice system, and stays in jail – like hospitals – can trigger significant changes in health status, treatment plans, and medication regimes. Local jail health programs should be called out and supported as critical members of health home networks and settings where "comprehensive transitional care" protocols should be encouraged. Jail health programs should be provided PRISM access to facilitate care coordination for Medicaid clients, and, in communities where they exist, jail release programs should be included as members of health home networks in order to assure no duplication of services with the designated care manager.
- **Include crisis services in care transitions and health home networks.** A subset of high- risk, high cost Medicaid clients have contact with the crisis system and in particular, Designated Mental Health Professionals (DMHPs) for involuntary commitment to psychiatric hospitals. In Strategy 2 where psychiatric hospitalization will be paid by health plans, DMHPs will need to work closely with care coordinators to identify less restrictive alternatives and diversion options from hospitalization.
- **Prevent administrative burdens associated with multiple managed care plans involvement in health homes.** Safety net health programs in King County may be contracting with multiple managed care plans. If each managed care plan organizes a health home network, it could result in a different set of protocols, tools and paperwork that would unduly burden the delivery system, impacting the overall cost effectiveness of providing Health Home services.
- **Clarify patient attribution.** The proposal is unclear regarding how patients who are involved in multiple delivery systems will select or be assigned to a health home. Because the target population is typically multi-system involved, and those systems may in turn be involved in

multiple health home networks, a clear process needs to be in place to determine the designated health home and assure that all entities involved with the client know who the designated care manager is.

- **For community health centers, the State should recognize the existing "qualification" system for health homes.** The proposed "qualification" system for health homes has elements of duplication with an effort that Washington's Community Health Centers (CHCs) are currently engaged in, as required by the Department of Health and Human Services Bureau of Primary Health Care—using Joint Commission or NCQA Patient Centered Medical Home (PCMH) standards. Washington's Health Centers have established a goal to achieve this recognition by 2013. For CHCs leading or participating in health home networks, this qualification should be recognized.
- **Clarify payment and sharing of savings**. The proposal lacks a description of the payment mechanisms for health home services. If funding flows through a managed care organization or other types of lead entities, how do funds reach the actual providers on the health home team and members of their network? We believe that savings or other incentives should be directed, in part, back to the health home network, including those members playing roles in non-clinical services shown to impact health outcomes and costs (e.g., housing). Another payment concern relates to outreach and engagement. Trust-building can take time in some subsets of the Medicaid population, and may precede their motivation to engage in health home assessments and care plans. In particular, health homes targeting homeless and mentally ill populations may warrant special funding for outreach and engagement activities, as well as to support smaller caseloads.
- **Provide flexibility on assessment tool requirements**. The required use of the Patient Activation Measurement (PAM) Self Management Support Tool is unduly restrictive and may not take into consideration the cultural appropriateness necessary to achieve patient engagement. High-risk clients often face numerous barriers (cognitive impairments, lack of trust, behavioral health issues, substance use, unmet basic needs for food and shelter, low literacy, etc.) such that timely compliance with specific assessment tools may not be realistic and could disrupt outreach and engagement progress among clients who most need the health home service.
- **Ensure culturally competent and linguistically responsive services**. The health homes proposal does not appear to adequately address issues regarding effective language access. Furthermore, we recommend the standards mandate screening, assessment, and evidence-based treatment protocols that have been normed on the population to be served and that can be translated effectively into other languages. When a specific protocol or intervention is not available, the State should include language that allows Evidence-based Practices to be culturally adapted to serve diverse populations.
- **Ensure the needs of children and adolescents are addressed**. While the proposal indicates that health homes will be available to individuals of all ages, the overall design of the health homes model does not appear to address the unique needs of children and youth with chronic conditions. While children and youth represent a small percentage of the high cost/high utilizer population, many children have significant needs, are multi-system involved and are at high risk of future chronic conditions that would move them into the high cost/high utilizing group.

We recommend that chronic conditions that are common in children and youth such as asthma, substance abuse and mental health disorders commonly diagnosed in childhood be included in the list of chronic conditions ensuring appropriate access to health homes for children and youth.

In closing, thank you for the opportunity to comment on the Draft Health Homes Proposal. We look forward to working with the DSHS and HCA to implement health homes as an opportunity to better coordinator care for the highest risk individuals in King County.

Sincerely,

Jackie MacLean, Director
Department of Community and Human Services

David Fleming, MD, Director & Health Officer
Public Health-Seattle & King County

Enclosure

cc: Anna Markee, Interim Health and Human Potential Policy Advisor, Office of the King County Executive
Susan McLaughlin, Health Care Reform Project Manager, Department of Community and Human Services
Janna Wilson, Senior External Relations Officer, Public Health-Seattle & King County